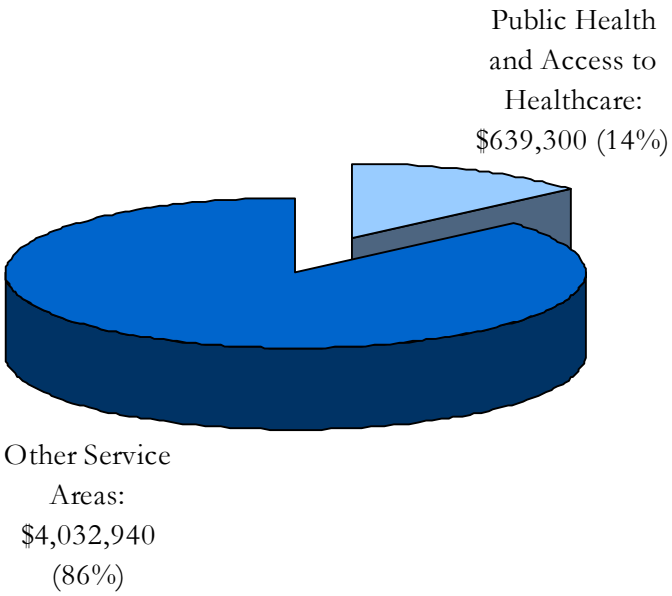
Public Health and Access to Healthcare

Goals and Services

Programs within this service area are primarily intended to improve the physical well-being of community members by encouraging healthy behaviors (e.g., better eating habits, physical activity, improving disease management, reducing smoking, tobacco use, and substance abuse; etc.); preventing disease (reducing its occurrence and impact); increasing medical preparedness for emergencies; and increasing access to quality health care and counseling. Some examples of services provided by programs within this service area are to: provide education; improve treatment, care, and support for persons living with or facing health concerns; provide case-management advocacy for additional or other client services; and promote environmental health.

Contracted Service Providers included in this Service Area

Percent of Investment in Public Health and Access to Healthcare and Other Service Areas, 2008



Highlights of Community Conditions

TCHHS/VS has departmental and contracted programs that offer public health and access to healthcare services. Services contracted through non-profits in this issue area focus their efforts on prevention of teen pregnancy and HIV/AIDS; promotion of better nutrition through increased accessibility to healthy foods; and improving outcomes for individuals with HIV/AIDS and individuals with disabilities. Please note that the scope of this summary is limited to our social service investments and does not include the roles and responsibilities assumed by the Travis County Healthcare District or the County's responsibilities for public heath carried out via an Interlocal agreement with the City of Austin.

Public health encompasses an array of services that work to improve community health outcomes. **Prevention efforts** focus on developing and implementing educational programs, policies, services, and research that target entire populations rather than individuals.[151] An additional focus of public health professionals is promotion of health care equity, quality, and accessibility, which requires addressing health disparities across all populations.[152]

The overall health status of the community informs public health policies and practices. Key health indicators, such as **birth outcomes and chronic disease rates, can serve as proxy measures** of community health. These indicators often point to underlying health issues in the community, such as high blood pressure, poor nutrition, or physical inactivity, and help to identify current community health needs.

- In 2004, the most recent year of available data, over a quarter of all Travis County mothers (26.5%) received inadequate prenatal care.[153] Inadequate prenatal care was more prevalent for African American mothers (28.6% of all African American mothers) and Hispanic mothers (35.2% of all Hispanic mothers).[154] An associated health outcome of inadequate prenatal care is **low birth weight** of the newborn (less than 5.5 pounds).[155] Low birth weight babies often have poorer health outcomes due to challenges in early stages of development.[156] Low birth weight babies comprised 7.1% of births in 2004.[157] African American babies had the largest percentage of low birth weights (13.1%), roughly twice the rate of all other race/ethnic groups.[158]

The prevalence and **incidence of sexually transmitted diseases** (STDs) **is another public health risk indicator**. Individuals engaging in unprotected sex may contract or spread these diseases; furthermore, unprotected sex can lead to HIV infections and unplanned pregnancies. STDs often go undiagnosed, and left untreated, can cause serious complications.[159]

- One in 378 Texans is living with **HIV/AIDS**, a 30% increase over the last five years.[160] African Americans are disproportionately impacted, comprising 11% of the total Texas population but representing 38% of individuals living with HIV/AIDS.[161] In 2007, there were 3,601 people living with HIV/AIDS in Travis County.[162] Of those, 164 were new HIV cases and 161 were new AIDS cases.[163] The first quarter of 2008 (January – March) saw higher numbers of new HIV and AIDS cases, compared to the prior year's first quarter. There were 48 new HIV cases and 51 new AIDS cases in the first quarter of 2008, versus 42 new HIV cases and 40 new AIDS cases in the first quarter of 2007.[164]

Chronic health conditions, such as diabetes and cardiovascular disease have associated costs, both monetary and personal. Direct costs of chronic health conditions include substantially higher medical expenses, often including hospitalization.[165] Indirect costs are more difficult to quantify but include absenteeism, lost work days, reduced productivity and premature death.[166]

- The top risk factors associated with **diabetes** are high blood pressure, high cholesterol, and obesity.[167] Diabetes prevalence in Texas rose to 10.3% of adults in 2007, and it continues to be the sixth leading cause of death in the state.[168] African Americans, Hispanics, and older adults have the highest rates of diabetes, and a substantial number of Texans are believed to have undiagnosed diabetes.[169] The prevalence of diabetes remains lower in Travis County, at 6.4%, and in the Austin-Round Rock Metropolitan Statistical Area (MSA), at 7.7%.[170]

- **Cardiovascular disease** risk factors include diabetes, smoking, obesity, poor nutrition, high cholesterol, high blood pressure, and lack of leisure time or physical activity.[171] The prevalence of cardiovascular disease (CVD) is lower in the Austin-Round Rock MSA, at 6.5%, compared to Texas (8.3%).[172] However, African Americans in the MSA have a higher prevalence (10.6%) than African Americans in the state (8.6%) and their rate exceeds the rates for all other gender and race/ethnic groups.[173] Overall, Austin-Round Rock MSA residents have a smaller prevalence of CVD risk factors versus the rest of the state. However, health disparities exist across race/ethnic groups, particularly in increased prevalence rates for African Americans.[174]

Cardiovascular Disease (CVD) Risk Factors
Austin-Round Rock MSA and Texas, 2007

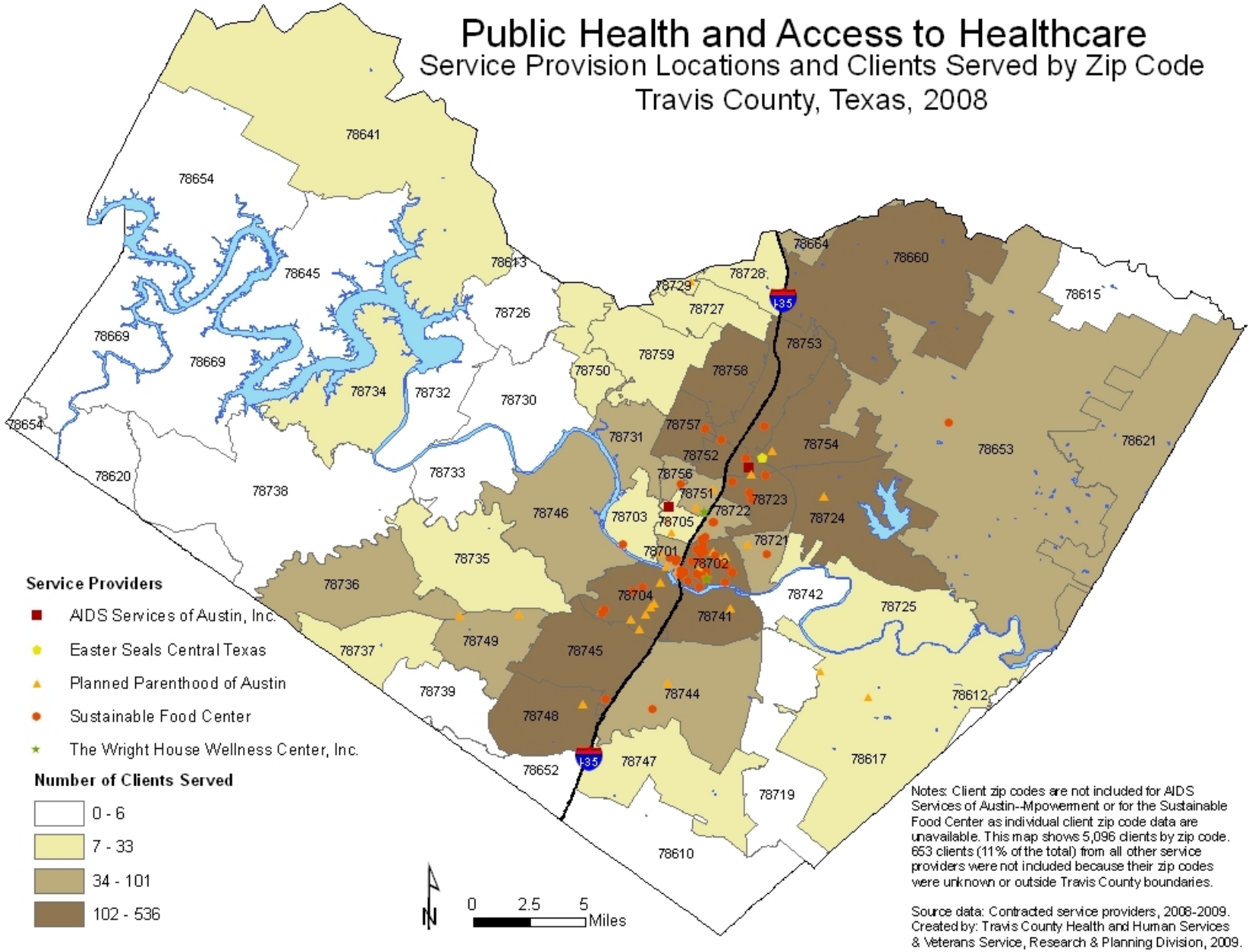
Risk Factor	Austin-Round Rock MSA	Texas
Diabetes	7.7%	10.4%
Current Smoker	17.2%	19.3%
Obesity (Body Mass Index >=30)	23.3%	28.6%
Poor Nutrition[bb]	73.1%	74.8%
High Blood Cholesterol	36.0%	38.5%
High Blood Pressure	24.1%	27.8%
No Leisure Time/Physical Activity	18.5%	28.3%

Created by: Travis County HHS/VS, Research and Planning Division, 2008
Source data: Texas Department of State Health Services, *Cardiovascular Health Facts 2005-2007*

Underlying our community response to these health conditions is access to affordable, quality care. **Health insurance** is an important component of health care accessibility as it directly impacts access to preventative healthcare, the affordability of therapeutic interventions (e.g., medicine, physical therapy, and behavioral health). Research indicates that individuals without health insurance are less likely to receive adequate preventative and therapeutic care and are more likely to experience adverse consequences of chronic diseases.[175] In 2007, a quarter of the population in Texas was uninsured.[176] Rates in Travis County are lower, with an estimated 19.3% of the population lacking health insurance.[177]

[bb] Poor nutrition is defined as eating fruits and vegetables less than 5 times per day.

The 81st legislative session is likely to influence state and local public health policies, with potential implications for health insurance coverage and public health and wellness efforts.[178] Furthermore, the administration change in the White House may also impact public health and access to healthcare, as health care reform is a prominent item on the agenda.[179]


Public Health and Access to Healthcare
Service Provision Locations and Clients Served by Zip Code
Travis County, Texas, 2008
78641
78654
78645
78613
78726
78669
78669
78734
78732
78730
78654
78620
78738
78733
78731
78729
78728
78727
78664
78660
78615
78759
78750
78758
78753
78757
78752
78754
78653
78621
78756
78751
78723
78722
78746
78703
78705
78724
78721
78735
78701
78702
78736
78704
78742
78725
78741
78737
78749
78745
78739
78744
78612
78748
78652
78747
78617
78719
78610
I-35
Service Providers
AIDS Services of Austin, Inc.
Easter Seals Central Texas
Planned Parenthood of Austin
Sustainable Food Center
The Wright House Wellness Center, Inc.
Number of Clients Served
0 - 6
7 - 33
34 - 101
102 - 536
N
0
2.5
5
Miles
Notes: Client zip codes are not included for AIDS Services of Austin--Mpowerment or for the Sustainable Food Center as individual client zip code data are unavailable. This map shows 5,096 clients by zip code. 653 clients (11% of the total) from all other service providers were not included because their zip codes were unknown or outside Travis County boundaries.
Source data: Contracted service providers, 2008-2009.
Created by: Travis County Health and Human Services & Veterans Service, Research & Planning Division, 2009.

AIDS Services of Austin, Inc.
Case Management

The Case Management program links clients to primary medical care and psychosocial, legal, financial, and other support services. It also coordinates and advocates for needed services. These services are intended to enhance the health and well-being of individuals and the community in the face of an evolving epidemic.

Funding

The total TCHHS/VS investment in the Case Management program for 2008 was $157,937. This investment comprised 25.5% of the total program budget. TCHHS/VS also funds the AIDS Services of Austin's Home Health Care Services, Food Bank / Nutritional Supplements, Nutritional Counseling, Mpowerment, and VOICES / VOCES programs, which are also described in the Public Health and Access to Healthcare issue area section.

Eligibility Criteria

To be eligible for case management services, clients must be HIV-positive, symptomatic, a resident of Travis County, and willing to work on HIV disease management goals.

Client Demographics

Over three-quarters (78%) of Case Management clients were male and nearly three-quarters (72%) were ages 37 to 55. Over a quarter (26%) of clients were Hispanic or Latino. More than half (59%) of clients were White and 39% were Black or African-American. Over a third (37%) of clients had incomes between 50% and 100% of the Federal Poverty Income Guideline level and more than a quarter (27%) had incomes below 50% of the Federal Poverty Income Guideline level. (See Appendix C for specific guideline income levels.)

Gender	Number	Percent
Female	90	20%
Male	353	78%
Balance – Not Specified	10	2%
Total	*453*	*100%*

Age	Number	Percent
18 to 24	6	1%
25 to 36	66	15%
37 to 55	327	72%
56 to 74	53	12%
75 and Over	1	0%
Total	*453*	*100%*

Ethnicity		
Hispanic or Latino	116	26%
Not Hispanic or Latino	337	74%
Total	*453*	*100%*

Race		
American Indian or Alaskan Native	2	0%
Asian	4	1%
Black or African American	176	39%
White	268	59%
Balance – Not Specified	3	1%
Total	*453*	*100%*

Income		
<50% of FPIL	123	27%
50% to 100%	169	37%
101% to 150%	77	17%
151% to 200%	45	10%
>200%	39	9%
Total	*453*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

A majority of clients in this program were located in eastern areas of Travis County. Over a quarter (28%) of clients resided in the East area and nearly a quarter (24%) were in the Northeast area. The Southeast area also had a sizeable share of the client population (14%). (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	7	1.5%
78705	4	0.9%
78751	6	1.3%
78756	13	2.9%
Total Central	*30*	*6.6%*

East		
78702	23	5.1%
78721	19	4.2%
78722	5	1.1%
78723	56	12.4%
78724	19	4.2%
78725	4	0.9%
Total East	*126*	*27.8%*

Other		
Other	15	3.3%
Total Other	*15*	*3.3%*

North	Number	Percent
78727	5	1.1%
78728	6	1.3%
78729	5	1.1%
78757	8	1.8%
78758	24	5.3%
78759	6	1.3%
Total North	*54*	*11.9%*

Northwest		
78641	1	0.2%
78645	1	0.2%
78730	2	0.4%
78731	2	0.4%
78732	2	0.4%
78750	4	0.9%
Total Northwest	*12*	*2.6%*

Northeast	Number	Percent
78653	3	0.7%
78660	11	2.4%
78752	49	10.8%
78753	35	7.7%
78754	9	2.0%
Total Northeast	*107*	*23.6%*

Southeast		
78617	3	0.7%
78741	49	10.8%
78744	4	0.9%
78747	5	1.1%
Total Southeast	*61*	*13.5%*

Southwest	Number	Percent
78704	18	4.0%
78735	1	0.2%
78736	3	0.7%
78745	12	2.6%
78748	3	0.7%
78749	4	0.9%
Total Southwest	*41*	*9.1%*

West		
78703	3	0.7%
78733	1	0.2%
78746	3	0.7%
Total West	*7*	*1.5%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

The Case Management program exceeded all output and outcome goals. Program staff members note that they received more returned surveys than expected (see the first outcome) and attribute this result to their efficiency and thoroughness in distributing the surveys to eligible clients through various modes of delivery (e.g., via the food pantry, dental clinic and mail outs). Volunteers were also utilized to ensure surveys were completed correctly. Staff members also report that case managers collaborate with clients to create workable service plans and negotiate attainable, yet significant, service plan goal objectives (see the second outcome). Case managers also keep in regular contact with clients and monitor client activities regarding overall management of their HIV disease (see the third outcome).

Case Management Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	453	425	107%
Number of units of case management provided	27,881	26,727	104%
Outcomes			
Percentage of clients surveyed who report satisfaction with case management services provided	95% (130/137)	80% (68/85)	119%
Percentage of clients making progress on their service plan objectives	85% (386/453)	80% (340/425)	107%
Percentage of clients receiving primary medical care based on "In-Care Verification" form	92% (415/453)	85% (361/425)	108%

AIDS Services of Austin, Inc.
Food Bank / Nutritional Supplements

Program Description
The Food Bank / Nutritional Supplements program offers assistance via provision of quality food, personal items, household hygiene products, and nutritional supplements for people who are symptomatic with HIV disease and who are at risk of declining health due to their inability to consume adequate food and nutrients.

Funding
The total TCHHS/VS investment in the Food Bank / Nutritional Supplements program for 2008 was $62,500. This investment comprised 35.8% of the total program budget. TCHHS/VS also funds the AIDS Services of Austin's Case Management, Home Health Care Services, Nutritional Counseling, Mpowerment, and VOICES / VOCES programs, which are also described in the Public Health and Access to Healthcare issue area section.

Eligibility Criteria
Clients must be symptomatic with HIV disease, reside in the Austin Transitional Grant Area (TGA), have an annual income at or below 150% of the Federal Poverty Income Guideline level, and be case-managed at AIDS Services of Austin or another AIDS service organization.

Client Demographics

Nearly three-quarters (74%) of clients were male and 23% were female. Three-quarters of clients were between the ages of 37 and 55 and over a quarter (27%) were Hispanic or Latino. Over a third (37%) of clients were White and a quarter were Black or African-American. Clients with an unspecified race accounted for 37% of the client population. Client income data were unavailable.

Gender	Number	Percent
Female	104	23%
Male	329	74%
Balance – Not Specified	12	3%
Total	*445*	*100%*

Ethnicity		
Hispanic or Latino	120	27%
Not Hispanic or Latino	323	73%
Balance – Not Specified	2	0.4%
Total	*445*	*100%*

Race		
American Indian or Alaskan Native	2	0.4%
Asian	2	0.4%
Black or African American	113	25%
White	163	37%
Balance – Not Specified	165	37%
Total	*445*	*100%*

Age	Number	Percent
18 to 24	3	1%
25 to 36	53	12%
37 to 55	332	75%
56 to 74	56	13%
75 and Over	1	0.2%
Total	*445*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

The majority of this program's clients were located in the eastern areas of Travis County. Over a quarter (28%) of clients resided in the East area and 22% of clients were in the Northeast area. The Southeast area accounted for 14% of clients. (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	11	2.5%
78705	2	0.4%
78751	7	1.6%
78756	21	4.7%
Total Central	*41*	*9.2%*

North	Number	Percent
78727	4	0.9%
78728	2	0.4%
78729	5	1.1%
78757	6	1.3%
78758	20	4.5%
78759	4	0.9%
Total North	*41*	*9.2%*

Northeast	Number	Percent
78621	4	0.9%
78660	7	1.6%
78664	1	0.2%
78752	47	10.6%
78753	32	7.2%
78754	7	1.6%
Total Northeast	*98*	*22.0%*

Southwest	Number	Percent
78704	18	4.0%
78735	1	0.2%
78736	2	0.4%
78745	12	2.7%
78748	2	0.4%
78749	2	0.4%
Total Southwest	*37*	*8.3%*

East		
78702	25	5.6%
78721	20	4.5%
78722	5	1.1%
78723	52	11.7%
78724	19	4.3%
78725	3	0.7%
Total East	*124*	*27.9%*

Northwest		
78641	1	0.2%
78654	1	0.2%
78730	2	0.4%
78731	1	0.2%
78732	1	0.2%
78750	3	0.7%
Total Northwest	*9*	*2.0%*

Southeast		
78617	2	0.4%
78741	46	10.3%
78744	10	2.2%
78747	5	1.1%
Total Southeast	*63*	*14.2%*

West		
78703	3	0.7%
78746	1	0.2%
Total West	*4*	*0.9%*

Other/Unknown		
Other	26	5.8%
Unknown	2	0.4%
Total Other/Unknown	*28*	*6.3%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

This program met or exceeded its performance goals for both output measures. Program staff members report that they had more new clients due to the economic downtown; furthermore, established clients came to the food bank on a more regular basis. These factors contributed to a higher number of units of food and nutritional supplements provided to clients (see the second output). Results from the annual client satisfaction survey (see the first outcome) were unavailable at the time this report was produced.

Food Bank / Nutritional Supplements Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	445	445	100%
Number of units of food and nutritional supplements provided	5,527	4,939	112%
Outcomes			
Percentage of clients surveyed who report satisfaction with quality of services	N.A.	80% (24/30)	N.A.

AIDS Services of Austin, Inc.
Home Health Care Services

Program Description
Home Health Care Services provides home health aide and homemaker services. These services help clients manage their illness in their home or living situation so that they are able to avoid hospitalization and nursing home placement.

Funding
The total TCHHS/VS investment in the Home Health Care Services program for 2008 was $20,000. This investment comprised 55.6% of the total program budget. TCHHS/VS also funds the AIDS Services of Austin's Case Management, Food Bank / Nutritional Supplements, Nutritional Counseling, Mpowerment, and VOICES / VOCES programs, which are also described in the Public Health and Access to Healthcare issue area section.

Eligibility Criteria
Clients are Travis County residents with symptomatic HIV disease who are in need of this service. Clients must also be homebound, in need of personal care assistance with activities of daily living, and ineligible for home health aide services through private insurance companies.

Client Demographics and Client Zip Codes
This program serves a small number of clients. Client demographic and zip code data are not reported to protect client privacy.

Performance Goals and Results

This program exceeded all performance goals except for the second output (or, the number of unduplicated clients served). Staff members explain that the program had difficulty receiving referrals for program services and continued to experience barriers experienced in the past surrounding refusal of services (e.g., utilization of family members for support, existing connection to homemaker/home health services, and distrust of third parties entering the home). Case managers were aggressively solicited for referrals but these efforts were not fruitful due to a lack of clients presenting as "homebound."

Staff members also note that some clients received home health services four times a week, rather than once or twice per week, leading to a greater number of units of service provided (see the first output). These services were able to support clients in their home environment (see the first outcome) and satisfactorily met client needs (see the second outcome).

Home Health Care Services Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of units of service provided	383	267	143%
Number of unduplicated clients served	6	10	60%
Outcomes			
Percentage of clients able to remain in their home	100% (6/6)	80% (8/10)	125%
Percentage of clients surveyed who report satisfaction with services provided	100% (6/6)	80% (8/10)	125%

AIDS Services of Austin, Inc.

Mpowerment

Program Description
The Mpowerment project is a community-level HIV prevention intervention for young gay men. The program aims to develop and support a gay-positive community to provide HIV prevention messages through a variety of means, including social settings, discussion groups, and information and materials designed by and for participants.

Funding
The total TCHHS/VS investment in the Mpowerment program for 2008 was $70,000. This investment comprised 40.2% of the total program budget. TCHHS/VS also funds the AIDS Services of Austin's Case Management, Home Health Care Services, Food Bank / Nutritional Supplements, Nutritional Counseling, and VOICES / VOCES programs, which are also described in the Public Health and Access to Healthcare issue area section.

Eligibility Criteria
The target population for this program is African American, Latino, and Anglo men who are ages 18 to 29 and who have sex with men, which is a risk factor for HIV transmission.

Client Demographics and Client Zip Codes
Individual client demographics and zip codes are unavailable, and thus, are not included.

Performance Goals and Results

The Mpowerment program exceeded all outcome measures and performed within the target range of performance for all but one output measure. Staff members explain that two Coordinators left during the year, and although they worked successfully to recruit Core Group clients (see the first output), it was challenging for the remaining Coordinator to maintain the number of social events and outreach activities alone (see the third and fourth outputs). Staff members attribute the success of the M-Group sessions (see the first and second outcomes) to the extra time added to these sessions, which allows for more discussion, exploration, and dialogue among the men and the facilitator.

Mpowerment Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated Core Group clients	175	131	134%
Number of unduplicated M-Group clients	93	100	93%
Number of social events participants	508	847	60%
Number of outreach activity participants	979	1,092	90%
Outcomes			
Percentage of men who attend an Unplugged session (M-Group) and report an HIV risk reduction strategy they feel they can attempt	87% (81/93)	60% (60/100)	145%
Percentage of men who attend an Unplugged session (M-Group) and report an increase in their perceived susceptibility related to personal risk of HIV/AIDS	89% (83/93)	80% (80/100)	112%

AIDS Services of Austin, Inc.

Nutritional Counseling

Program Description

Nutritional Counseling services help clients use food products in the best way possible to maintain or improve health and to maximize the health benefits of the agency's Food Bank and Nutritional Services programs.

Funding

The total TCHHS/VS investment in the Nutritional Counseling program for 2008 was $16,000. This investment comprised 37.7% of the total program budget. TCHHS/VS also funds the AIDS Services of Austin's Case Management, Home Health Care Services, Food Bank / Nutritional Supplements, Mpowerment, and VOICES / VOCES programs, which are also described in the Public Health and Access to Healthcare issue area section.

Eligibility Criteria

This program serves individuals with symptomatic HIV disease, who are case-managed in the Austin Transitional Grant Area (TGA), and are at or below 150% of the Federal Poverty Income Guideline level.

Client Demographics

Over three-quarters (76%) of clients were male and 23% were female. Nearly three-quarters (73%) of clients were in the 37 to 55 age range and 24% were Hispanic or Latino. Over a third (38%) of clients were White and 31% were Black or African-American. Clients with an unspecified race reported accounted for 31% of clients. Most (95%) clients had incomes at or below 150% of the Federal Poverty Income Guideline level. Please note that clients with incomes greater than 150% of the Federal Poverty Income Guideline level are supported through funding sources other than Travis County. (See Appendix C for specific guideline income levels.)

Gender	Number	Percent
Female	57	23%
Male	191	76%
Balance – Not Specified	4	2%
Total	*252*	*100%*

Age	Number	Percent
18 to 24	3	1%
25 to 36	29	12%
37 to 55	185	73%
56 to 74	35	14%
Total	*252*	*100%*

Ethnicity		
Hispanic or Latino	60	24%
Not Hispanic or Latino	192	76%
Total	*252*	*100%*

Race		
Asian	2	1%
Black or African American	77	31%
White	95	38%
Balance – Not Specified	78	31%
Total	*252*	*100%*

Income		
<50% of FPIL	79	31%
50% to 100%	117	46%
101% to 150%	44	17%
151% to 200%	9	4%
>200%	3	1%
Total	*252*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

The majority of Nutritional Counseling clients resided in eastern areas of Travis County. Over a quarter (28%) of clients were located in the East area and 23% were in the Northeast area. The Southeast area accounted for 16% of the client population. (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	8	3.2%
78705	1	0.4%
78751	4	1.6%
78756	13	5.2%
Total Central	*26*	*10.3%*

North	Number	Percent
78727	2	0.8%
78729	3	1.2%
78757	6	2.4%
78758	10	4.0%
78759	2	0.8%
Total North	*23*	*9.1%*

Northeast	Number	Percent
78653	2	0.8%
78660	5	2.0%
78752	32	12.7%
78753	17	6.7%
78754	2	0.8%
Total Northeast	*58*	*23.0%*

Southwest	Number	Percent
78704	10	4.0%
78745	7	2.8%
78748	2	0.8%
Total Southwest	*19*	*7.5%*

East		
78702	8	3.2%
78721	13	5.2%
78722	5	2.0%
78723	36	14.3%
78724	8	3.2%
78725	1	0.4%
Total East	*71*	*28.2%*

Northwest		
78730	1	0.4%
78731	1	0.4%
78732	1	0.4%
78750	2	0.8%
Total Northwest	*5*	*2.0%*

Southeast		
78617	1	0.4%
78741	29	11.5%
78744	8	3.2%
78747	3	1.2%
Total Southeast	*41*	*16.3%*

West		
78703	2	0.8%
Total West	*2*	*0.8%*

Other/Unknown		
Other	1	0.4%
Unknown	6	2.4%
Total Other/Unknown	*7*	*2.8%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

The Nutritional Counseling program greatly exceeded the target range of performance for both output measures. Program staff members note that there was substantial expansion of the program in 2008, which included hiring an additional nutritionist and increasing the hours available to clients. As a result, more clients were served (see output 1) and many clients had longer sessions with the nutritionist; thus, more units of service were delivered (see output 2). Results from the annual client satisfaction survey were unavailable at the time this report was produced.

Nutritional Counseling Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	252	85	297%
Number of units of service delivered	3,154	930	339%
Outcomes			
Percentage of clients surveyed who report satisfaction with overall quality of services received	N.A.	77% (13/17)	N.A.

AIDS Services of Austin, Inc.
VOICES / VOCES

Program Description
The Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES) program provides a one-hour, evidence-based intervention. This program gives participants additional knowledge about HIV/STD risks, condom usage as a prevention strategy, the types of condoms available, and the availability of HIV-related services. Participants also develop additional skills in negotiating safer sex practices with sexual partners regarding condom use.

Funding
The total TCHHS/VS investment in the VOICES / VOCES program for 2008 was $65,000. This investment comprised 32.4% of the total program budget. TCHHS/VS also funds the AIDS Services of Austin's Case Management, Home Health Care Services, Food Bank / Nutritional Supplements, Nutritional Counseling, and Mpowerment programs, which are also described in the Public Health and Access to Healthcare issue area section.

Eligibility Criteria
VOICES/VOCES targets high-risk heterosexual persons of color and men who have sex with men. The Texas Department of Health identified this population as most affected by HIV and AIDS in the "2003 Epidemiological Profile in the South I35 Corridor High Morbidity Analysis Zone (HMAZ)," a study that included Travis County. Clients are not required to document their eligibility for this program, but staff members collect anonymous, self-reported client demographic (including zip code), risk factor, sex partner risk factor, substance abuse, HIV status, and history of sexually transmitted diseases.

Client Demographics

A slight majority (56%) of this program's clients were male and 44% were female. Over a third (38%) of clients were ages 37 to 55 and nearly a third (32%) were in the 25 to 36 age range. Hispanic or Latino clients accounted for 17% of the client population. A majority (65%) of clients were White and 29% were Black or African-American. Due to the anonymity of this program, client income data are not collected.

Gender	Number	Percent
Female	445	44%
Male	570	56%
Balance – Not Specified	1	0.1%
Total	*1,016*	*100%*

Ethnicity		
Hispanic or Latino	175	17%
Not Hispanic or Latino	841	83%
Total	*1,016*	*100%*

Race		
American Indian or Alaskan Native	14	1%
Asian	7	1%
Black or African American	291	29%
Native Hawaiian or Other Pacific Islander	2	0.2%
White	665	65%
Balance – Not Specified	37	4%
Total	*1,016*	*100%*

Age	Number	Percent
13 to 17	26	3%
18 to 24	161	16%
25 to 36	327	32%
37 to 55	391	38%
56 to 74	97	10%
75 and Over	5	0.5%
Balance – Not Specified	9	1%
Total	*1,016*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

The East and Southwest areas each accounted for 20% of the client population. The Southeast area also had a sizeable share of the population (13%). Clients with an unknown zip code comprised 22% of clients. Staff members explain that some program clients have left prison and/or drug treatment and may not have a zip code to report, while other clients may not consider the transitional living facility their permanent zip code. (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	48	4.7%
78705	5	0.5%
78751	4	0.4%
Total Central	*57*	*5.6%*

East		
78702	139	13.7%
78721	18	1.8%
78722	1	0.1%
78723	23	2.3%
78724	16	1.6%
78725	2	0.2%
Total East	*199*	*19.6%*

Other/Unknown		
Other	1	0.1%
Unknown	221	21.8%
Total Other/Unknown	*222*	*21.9%*

North	Number	Percent
78727	1	0.1%
78728	5	0.5%
78729	3	0.3%
78757	10	1.0%
78758	24	2.4%
78759	10	1.0%
Total North	*53*	*5.2%*

Northwest		
78641	7	0.7%
78645	2	0.2%
78654	3	0.3%
78669	3	0.3%
78726	2	0.2%
78731	5	0.5%
78732	2	0.2%
78734	6	0.6%
78750	4	0.4%
Total Northwest	*34*	*3.3%*

Northeast	Number	Percent
78621	4	0.4%
78653	1	0.1%
78660	8	0.8%
78664	6	0.6%
78752	22	2.2%
78753	18	1.8%
78754	8	0.8%
Total Northeast	*67*	*6.6%*

Southeast		
78610	3	0.3%
78617	7	0.7%
78719	1	0.1%
78741	75	7.4%
78742	4	0.4%
78744	32	3.1%
78747	5	0.5%
Total Southeast	*127*	*12.5%*

Southwest	Number	Percent
78704	51	5.0%
78735	6	0.6%
78736	3	0.3%
78737	1	0.1%
78745	103	10.1%
78748	26	2.6%
78749	9	0.9%
Total Southwest	*199*	*19.6%*

West		
78620	4	0.4%
78703	3	0.3%
78733	2	0.2%
78746	49	4.8%
Total West	*58*	*5.7%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

This program exceeded all performance goals. Staff members attribute the program's success to their strategic approach in the delivery of the VOICES intervention. They have developed strong relationships with local providers in drug treatment facilities, aftercare programs, the local housing authority, and other service organizations in the community, helping to establish ideal locations to reach clients. The program offers many of their clients a pre-HIV 101 session prior to the VOICES intervention. Staff attribute the increase in the percentage of clients who successfully meet the behavioral outcomes (see the first and second outcomes) to this extra session, which allows more time for clients to ask questions and to become engaged to participate fully in the intervention.

VOICES / VOCES Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	1,024	845	121%
Number of clients that complete a questionnaire	1,016	676	150%
Outcomes			
Percentage of clients who complete the VOICES/VOCES intervention and report an increase in self-efficacy regarding condom use	86% (875/1,016)	75% (507/676)	115%
Percentage of clients who complete the VOICES/VOCES intervention and report increased knowledge regarding different types of condoms available	86% (870/1,016)	60% (406/676)	143%

Easter Seals Central Texas
Developmental and Clinical Solutions

Program Description
The goal of the Easter Seals Central Texas' (ESCT) Developmental and Clinical Solutions program is to provide, through non-duplicative service delivery collaboration, a continuum of care for individuals with disabilities in the areas of health and clinical rehabilitation and wrap-around services. The program provides comprehensive service coordination, training, and support services to individuals with significant disabilities. Through these services, the program strives to help clients continue to live in the community; promote independent functioning; and prevent exploitation, neglect, abuse, and institutionalization of people with disabilities.

Funding
The total TCHHS/VS investment in the Developmental and Clinical Solutions program for 2008 was $123,241. This investment comprised 3.1% of the total program budget. TCHHS/VS also funds Easter Seals Central Texas' Employment Solutions program, which is described in the Workforce Development issue area section.

Eligibility Criteria
Developmental and Clinical Solutions serves children and adults with a variety of physical and neurological disabilities. The population served is primarily low-income (i.e., less than 200% of the Federal Poverty Income Guideline level).

Client Demographics

Most (60%) clients were male, and virtually all (95%) were age 5 and under. The majority (66%) of clients were Hispanic or Latino. In terms of race, approximately three-quarters (76%) were White. Client income data were unavailable.

Gender	Number	Percent
Female	755	40%
Male	1,128	60%
Total	*1,883*	*100%*

Ethnicity		
Hispanic or Latino	1,249	66%
Not Hispanic or Latino	616	33%
Balance – Not Specified	18	1%
Total	*1,883*	*100%*

Race		
American Indian or Alaskan Native	1	0.1%
Asian	27	1%
Black or African American	343	18%
Native Hawaiian or Other Pacific Islander	26	1%
White	1,440	76%
Balance – Multiple Races	46	2%
Total	*1,883*	*100%*

Age	Number	Percent
5 and Under	1,781	95%
6 to 12	47	2%
13 to 17	9	0.5%
18 to 24	4	0.2%
25 to 36	13	1%
37 to 55	12	1%
56 to 74	12	1%
75 and Over	5	0.3%
Total	*1,883*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

Prior to entering the program, approximately half (52.9%) of clients resided in the Northeast section of Travis County. The next largest percentage (20.1%) resided in the East section of the County, and 19.2% resided in the North section. (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	1	0.1%
78705	3	0.2%
78712	6	0.3%
78751	27	1.4%
78756	11	0.6%
Total Central	*48*	*2.5%*

East		
78721	2	0.1%
78722	18	1.0%
78723	201	10.7%
78724	156	8.3%
78725	1	0.1%
Total East	*378*	*20.1%*

Other/Unknown		
Other	17	0.9%
Unknown	8	0.4%
Total Other/Unknown	*25*	*1.3%*

North	Number	Percent
78727	7	0.4%
78728	4	0.2%
78729	1	0.1%
78757	79	4.2%
78758	262	13.9%
78759	9	0.5%
Total North	*362*	*19.2%*

Northwest		
78641	3	0.2%
78731	38	2.0%
78734	1	0.1%
78750	4	0.2%
Total Northwest	*46*	*2.4%*

Northeast	Number	Percent
78621	32	1.7%
78653	81	4.3%
78660	307	16.3%
78664	35	1.9%
78752	154	8.2%
78753	307	16.3%
78754	80	4.2%
Total Northeast	*996*	*52.9%*

Southeast		
78610	2	0.1%
78741	5	0.3%
78744	2	0.1%
Total Southeast	*9*	*0.5%*

Southwest	Number	Percent
78704	2	0.1%
78745	5	0.3%
78748	4	0.2%
Total Southwest	*11*	*0.6%*

West		
78703	8	0.4%
78746	1	0.1%
Total West	*9*	*0.5%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

The Developmental and Clinical Solutions program exceeded all performance measures. In particular, the program far exceeded the goal for the second output, which captures the number of hours of service delivered. Program staff members explain that the agency's early childhood intervention program has continued to expand — over 70% over the last year. In turn, the number of clients served in this program has grown, as have the number of hours delivered.

Staff members report that the increased demand for these services primarily stems from population growth in the principal areas served, such as Manor and Pflugerville, and from increased outreach efforts. The Child Find Coordinator and Marketing Coordinator spearhead the program's outreach efforts and have initiated strategies, over the last year, to reach deeper into the community. One of the Coordinators also solidified the agency's relationship with Seton Hospital, which has also increased referrals. A slight increase in funding from the state, matching funders, and sliding-scale fees contributed to the agency's ability to serve these additional clients.

Developmental and Clinical Solutions Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	1,883	1,704	111%
Number of hours of service delivered	49,005	28,698	171%
Outcomes			
Percentage of surveyed clients reporting satisfaction with services received	95% (392/413)	80% (320/400)	119%
Percentage of surveyed MR/DD clients showing improved development, functioning, and/or quality of life and/or achieving/maintaining goals on individual service plan	83% (711/858)	80% (400/500)	104%

Planned Parenthood of Austin Family Planning, Inc.
Teen Pregnancy Prevention Grant

Program Description
The goals of this Planned Parenthood program are to help reduce teen pregnancy and keep all peer educators pregnancy-free during the length of the program. This program provides one-hour sessions that include discussion of birth control methods, identification and prevention of sexually transmitted diseases, and communication skill development.

Funding
The total TCHHS/VS investment in the Teen Pregnancy Prevention Grant program for 2008 was $29,601. This investment comprised 36.9% of the total program budget.

Eligibility Criteria
This program serves teens, their parents, and other adults who routinely interact with teens. Clients are concentrated in the central Austin area. The Health Educator recruits teens from Austin Independent School District (AISD) area high schools to participate in the Teen Peer Education Program. The schools are targeted because they were identified as areas in which residents are at high risk for unintended pregnancy, have a higher concentration of adverse health risks, and have a greater likelihood of dropping out of school. This program also accepts referrals into the program from other social service agencies.

Client Demographics

Approximately three-quarters (76%) of clients were female, and half were between the ages of 13 and 17. Nearly a third (31%) of clients were Hispanic or Latino. In terms of race, 68% of clients were White and 30% were Black or African American. Client income data were not required.

Gender	Number	Percent
Female	1,156	76%
Male	372	24%
Total	*1,528*	*100%*

Ethnicity		
Hispanic or Latino	468	31%
Not Hispanic or Latino	1,040	68%
Balance – Not Specified	20	1%
Total	*1,528*	*100%*

Race		
American Indian or Alaskan Native	7	0.5%
Asian	5	0.3%
Black or African American	451	30%
White	1,042	68%
Balance – Not Specified	23	2%
Total	*1,528*	*100%*

Age	Number	Percent
6 to 12	45	3%
13 to 17	771	50%
18 to 24	309	20%
25 to 36	195	13%
37 to 55	198	13%
56 to 74	10	1%
Total	*1,528*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

Prior to entering the program, 31.9% of clients resided in the Southwest section of Travis County. Nearly a quarter (22.5%) of clients resided in the East section of the County. (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	15	1.0%
78712	108	7.1%
78751	40	2.6%
Total Central	*163*	*10.7%*

North	Number	Percent
78729	14	0.9%
Total North	*14*	*0.9%*

Northeast	Number	Percent
78752	12	0.8%
78754	159	10.4%
Total Northeast	*171*	*11.2%*

Southwest	Number	Percent
78704	277	18.1%
78736	46	3.0%
78737	17	1.1%
78748	63	4.1%
78749	85	5.6%
Total Southwest	*488*	*31.9%*

Other/Unknown		
Other	338	22.1%
Unknown	10	0.7%
Total Other/Unknown	*348*	*22.8%*

East		
78702	332	21.7%
78722	12	0.8%
Total East	*344*	*22.5%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

Planned Parenthood met the target range of performance expectations. The program greatly exceeded the goals for the first output, which measures the number of clients served. Program staff members report that this result is primarily due to receiving additional funding, which allowed the program to hire a second Health Educator. An increase in school administrators' interest in implementing the program at their schools also contributed to this result.

Teen Pregnancy Prevention Grant Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	1,528	803	190%
Number of hours health educators provided facilitation	1,070	1,070	100%
Number of teens who participated in the peer education program	27	28	96%
Number of young people who received peer-to-peer sexuality education	417	429	97%
Outcomes			
Percentage of clients who demonstrated increased knowledge	76% (659/867)	80% (643/803)	95%
Percentage of teens who remained pregnancy free throughout their participation in the program	100% (27/27)	100% (28/28)	100%

Sustainable Food Center

Community and Youth Gardening

Program Description

The Sustainable Food Center serves to increase the availability and consumption of locally-grown, healthy foods by low-income children and adults. Community and Youth Gardening (formerly know as Spread the Harvest) is a community-based program that helps low-income individuals and families grow nutritious produce for their own consumption and encourages them to spread the harvest among their neighbors or through area food banks.

Funding

The total TCHHS/VS investment in the Community and Youth Gardening Grant program for 2008 was $19,321. This investment comprised 39.2% of the total program budget.

Eligibility Criteria

This program targets underserved children and adults within Travis County. The program includes residents who are at or below 200% Federal Poverty Income Guideline level; children and adults who are at risk for household food insecurity and/or face a higher risk of diet-related problems; schools with a majority of economically disadvantaged students;[cc] and underserved residents of STEPS to a Healthier Austin target zip codes.

Client Demographics and Client Zip Codes

Individual client demographics and zip codes are unavailable and, thus, are not included.

[cc] Economically disadvantaged students are defined as those eligible for free or reduced-priced meals under the National School Lunch and Child Nutrition Program.

Performance Goals and Results

Community and Youth Gardening met the target range of expectations for all performance measures. The program greatly exceeded the first and third output for several reasons.

In 2008, the TCHHS/VS contract for this program expanded to include the entire Community and Youth Gardening program – not only the Spread the Harvest program. The performance goals underestimated the impact of this change. In the 2009 contract, the performance goals have been increased significantly to address this discrepancy. Additionally, the demand for these services also rose due to an increase in community events, including workshops, presentations, installation of new community gardens, and a garden fair. The program also established a new partnership with Linder Elementary School to assist with their school garden. With this increase in the number of program participants also came an increase the number of gardeners sharing their harvest. Moreover, yields for some gardeners were larger than expected.

The recent economic downturn may have also contributed to the increase in participants. Specifically, in the last quarter, program staff observed an increase in the number of people with higher incomes requesting services in order to grow their own food due to an increase in food costs, especially fresh produce.

Community and Youth Gardening Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	1,745	435	401%
Number of meal equivalents (garden fresh produce shared by gardeners; two meal equivalents fit into one plastic grocery-store bag)	2,576	2,655	97%
Number of meal recipients (persons receiving one or more meal equivalents)	1,950	1,021	191%
Outcomes			
Percentage of Community and Youth gardeners sharing meal equivalents	88% (414/470)	80% (350/435)	110%
Percentage of surveyed Community and Youth gardeners reporting increased knowledge and skills	99% (458/463)	90% (392/435)	110%
Percentage of surveyed Community and Youth gardeners who report being satisfied with the services provided	98% (444/451)	95% (414/435)	103%

The Wright House Wellness Center, Inc.
Case Management

Program Description
The Wright House Wellness Center's Case Management program assists clients in accessing and staying in primary medical care, adhering to medical treatment regimens, increasing self-sufficiency, and maintaining or increasing quality of life. The Case Management program serves as the clients' primary link to HIV medical care, essential needs, and other community resources and information.

Funding
The total TCHHS/VS investment in the Case Management program for 2008 was $75,700. This investment comprised 47.3% of the total program budget.

Eligibility Criteria
The Case Management program serves HIV positive "disadvantaged" individuals living in Travis County. The Wright House Wellness Center defines disadvantaged as one or more of the following: low socioeconomic status, lack of sufficient education, hard-to-reach, underserved and/or out of care, low/no social support, homeless, co-morbid health conditions, mental health/substance abuse issues, criminal justice issues, and other similar challenges.

Client Demographics

Over two-thirds (69%) of Case Management clients were male and a majority (61%) of clients were ages 37 to 55. Of note, this program also served a younger population compared to other funded programs in this issue area. Over a quarter (27%) of clients were Hispanic or Latino. In terms of race, over half (55%) of clients were White and over a third (37%) were Black or African-American. Clients with incomes between 50% and 100% of the Federal Poverty Income Guideline level comprised 36% of clients, and clients with incomes less than 50% of the Federal Poverty Income Guideline level accounted for 34% of clients. (See Appendix C for specific guideline income levels.)

Gender	Number	Percent
Female	48	29%
Male	115	69%
Balance – Not Specified	3	2%
Total	*166*	*100%*

Age	Number	Percent
6 to 12	1	1%
18 to 24	5	3%
25 to 36	46	28%
37 to 55	102	61%
56 to 74	12	7%
Total	*166*	*100%*

Ethnicity		
Hispanic or Latino	45	27%
Not Hispanic or Latino	121	73%
Total	*166*	*100%*

Race		
American Indian or Alaskan Native	1	1%
Black or African American	61	37%
White	91	55%
Balance – Not Specified	13	8%
Total	*166*	*100%*

Income		
<50% of FPIL	56	34%
50% to 100%	59	36%
101% to 150%	25	15%
151% to 200%	10	6%
>200%	6	4%
Balance – Not Specified	10	6%
Total	*166*	*100%*

Note: Percentages may not total 100 due to rounding.

Client Zip Codes

The greatest percentages of the client population were from the Northeast (19%) and Southeast (19%) areas of Travis County. The next largest shares were located in the Southwest (16%), East (15%), and North (13%) areas of the county. (See Appendix E for zip code classification map.)

Central	Number	Percent
78701	1	0.6%
78705	4	2.4%
78756	10	6.0%
Total Central	*15*	*9.0%*

East		
78702	9	5.4%
78721	2	1.2%
78722	2	1.2%
78723	8	4.8%
78724	2	1.2%
78725	1	0.6%
Total East	*24*	*14.5%*

North	Number	Percent
78727	3	1.8%
78729	1	0.6%
78757	5	3.0%
78758	11	6.6%
78759	2	1.2%
Total North	*22*	*13.3%*

Northwest		
78731	2	1.2%
Total Northwest	*2*	*1.2%*

Northeast	Number	Percent
78621	1	0.6%
78653	1	0.6%
78664	5	3.0%
78752	13	7.8%
78753	12	7.2%
Total Northeast	*32*	*19.3%*

Southeast		
78617	3	1.8%
78719	1	0.6%
78741	20	12.0%
78744	8	4.8%
Total Southeast	*32*	*19.3%*

Southwest	Number	Percent
78704	8	4.8%
78745	14	8.4%
78748	3	1.8%
78749	1	0.6%
Total Southwest	*26*	*15.7%*

West		
78703	2	1.2%
Total West	*2*	*1.2%*

Other/Unknown		
Other	7	4.2%
Unknown	4	2.4%
Total Other/Unknown	*11*	*6.6%*

Note: Percentages may not total 100 due to rounding.

Performance Goals and Results

The Case Management program met all performance measure goals. Notably, the program greatly exceeded the total number of clients served (see the first output). Staff members report that this is due to high numbers of continuing clients and requests for service. They also note that the number of clients surveyed fell short of expectations due to clients inadvertently skipping questions or choosing not to complete questions on the client satisfaction survey. However, completed surveys reported high levels of satisfaction with services provided (see the second outcome)

Case Management Performance Measures, Actual Results, and Goals for 2008

Performance Measure	Total Program Performance Results	Total Program Performance Goals	% of Total Program Performance Goal Achieved
Outputs			
Number of unduplicated clients served	166	100	166%
Number of units of service provided (one unit equals 15 minutes)	5,902	6,146	96%
Outcomes			
Percentage of clients successfully linked/maintained in primary medical care	95% (157/166)	100% (100/100)	95%
Percentage of clients who reported satisfaction with the services provided	91% (41/45)	80% (64/80)	114%